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OPHTHALMOLOGY AND OTOLOGY.

Abscess of the Brain.

BY J. E. MINNEY, A.M., M.D.
R. S. MAGEE, A.M., M.D.

Report of a case to the Topeka Academy of Medicine and Surgery, January, 1895.

Mr. M., 33 years old, unmarried, of Silver Lake, Kas., consulted me December 4, 1894, for earache.

History—His left ear had troubled him for twenty years, beginning when a boy with earache and then a discharge from that ear would follow. At times the ear appeared to be well, although the hearing was impaired in that ear from the first attack. The last attack came on about four weeks ago. There is some pain and dizziness and nausea. The appetite is not very good and there is a tendency to constipation and restlessness at night and pain in the head, increased when lying down.

Inspection—The skin is not clear but boggy looking and the conjunctiva is more or less congested and rather dirty in appearance. He was slow in speech and appeared to study when asked a question, although a simple one, before answering. This I attributed at first as natural to him, but later on found that it increased and was a symptom of serious brain lesion. There was a tendency to a subnormal pulse and temperature throughout his sickness, although once or twice the temperature arose to 101° and the pulse to 84. The bony portion of the auditory canal was closed from swelling of the soft tissue, and pus was escaping from it. The probe pressed against the soft swollen tissues lining the canal, entered the canal, and firm pressure upwards allowed a quantity of fetid pus to escape, and showed the opening from which the pus escaped to be above or in the roof of the canal just beyond the constricted part of the bony portion. Pressure caused no pain, but an uneasy sensation and a sense of heaviness or dullness.

Diagnosis guarded, bnt feared that the brain was involved.

Treatment—Peroxide of hydrogen and gentle pressure and washing to get rid of all pus possible. This was done daily or every second day, as he could come from Silver Lake, until the 13th, when he felt so much better that he insisted on careing for his ear at home and coming to see me when he felt the need of it. He was given internally ⅙ of a grain of calomel three times a day as a tonic and to overcome his obstipation. He also took a few 3-grain doses of quinine, as he said he was troubled at times with malaria and felt the effects of it some at the time. On the 15th of the month I was telephoned to see him at his home (Silver Lake). I responded to the call, taking my son Earnest with me. On our arrival at 9 P.M. we met Dr. Dudley, the family physician. The doctor said that Mr. M. had been struck on the side of the head a severe blow on the night of November 13, 1894, and he had not been free from head trouble since. Aside from this Mr. M. had called on him only a few times for something to relieve the pain in his ear. On examination we found the patient in a semi-comatose condition, pulse 48, temperature subnormal, and just getting over a chill. The breath was characteristic of brain abscess, pungent, cutting and penetrating, clinging and offensive to nauseating, and once smelled never to be forgotten.

Amnesic aphasia had increased rapidly during the past two days.

Diagnosis— Abscess of the brain as a sequellæ of chronic suppuration of the middle ear. This opinion was mutually concurred in by Dr. Dudley and myself.

Prognosis—Death within a week to ten days at most.

Treatment—Owing to the original trouble being in the middle ear and the pus not having free vent from the auditory canal, we thought possibly that drainage could be obtained through the mastoid although it was a forlorn hope. Accordingly my son chloroformed the patient and Dr. Dudley and I opened the mastoid with the trephine. The patient rallied nicely, but no better drainage was secured. When it was found that no good had resulted from the mastoid opening my son insisted on opening into the brain at the prospective site of the abscess just above the ear into the middle lobe, I demurred, owing, as I thought, to the imminent death of the patient no matter what was done.

In the interest of propressive surgery and in compliance with my promise in an exactly similar case reported to this society about two years ago, he was right; but the practical thing to do in this case Dr. Dudley and I thought was to let the brain surgery alone. The doctor said he would obtain a post mortem if possible. In three or four days the doctor reported the family willing for the autopsy.

Death occurred on the 23d of December during my absence from the city, and Drs. Dudley and Magee made the post mortem examination, which the latter will now report.

Report of Autopsy—Abscess of the Brain.

On the evening of December 24, at the request of friends and the family, I made a post mortem examination of the brain of H. M., deceased. In this examination I was kindly assisted by Drs. Dudley & Magill, of Silver Lake.

On removing the calvarium the meningeal vessels were found to be very much distended —showing a deep blue color characteristic of meningitis.

Beginning in front, loosening the dura mater from the crista galli and proceeding backwards as soon as I reached the pituitary body, I clipped the infundibulum—the connecting link between the tuber cinerum and the pituitary body, and containing a funnel-shaped opening which communicates with the third ventricle, which, as you all know, communicates by means of the foramen of monno to the lateral ventricles. Almost instantly, as soon as the opening was made into the infundibulum, a greenish-colored, most loathesome smelling pus exuded in quite a considerable quantity, so that I had to sponge before proceeding further. After removal of the brain a dark spot was seen at the base of the third temporo sphenoidal convolution. Puncturing this the same before mentioned pus ran out.

Just external to the eminence for the top —semi-circular—and on the crest was an area of necrosed bone, extending downwards and backwards to the lateral sinus and involving its anterior walls. Making gentle pressure on this necrosed area I was able to break down the surrounding adjacent bone to a rough jagged circle the size of a quarter of a dollar. The odor of this necrosed bone and the pus in the abscess was similar, if my nose did not deceive me. In all my experience in dissecting rooms, five years, I have never had anything quite so offensive. It was double-distilled essence of green rottenness. Some of the friends in the room watching the post mortem said that the smell of the pus was exactly similar to the odor of the breath for the past ten days or two weeks.

In order to reach this abscess I had to cut through the dura. No pus was seen in the meninges or external to the dura anywhere. In the region of the inferior occipital lobes, on this same side (left), the dural surface showed a contused appearance, probably due to pressure. Small pieces of clots were also seen clinging to the walls of the lateral sinus next to the necrosed area of bone.

The night was cold and I put the brain up on the roof till morning and after reaching home immersed it in bichloride solution. I turned the specimen over to Dr. Gilbert, who will now exhibit it as to the morbid anatomy and extent of abscess cavity.

Dr. Gilbert will report in full the macroscopic and microscopic appearance of the brain. He is now making cultures of the pus taken from the abscess and will report in full. (This report will be published in future issue.—ED.)

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Treatment of Traumatic Cataract by Extraction of the Lens.

BY JAMES MOORES BALL, M.D.

Professor of Ophthalmology and Otology in the St. Louis College of Physicians and Surgeons.

Abstract of a paper read before the Mississippi Valley Medical Association, at Hot Springs, Ark., November 23, 1894.

Cases of lenticular opacity, caused by a foreign body which remains within the eye are always extremely dangerous owing to the introduction of pyogenic germs on the one hand, and the dangers of sympathetic ophthalmia on the other. Such cases must always remain an opprobrium to ophthalmology. However, there are many cases of traumatic cataract attended by rapid increase of intra-ocular tension, peri-corneal injection, iritis or irido-cyclitis and ultimate excavation of the optic nerve head in which the foreign body either lodges in the lens or is withdrawn at the time of injury. It is concerning such cases that I wish to speak.

For years the practice of the profession has been to use atropia if the symptoms be not severe, and to perform linear extraction if the symptoms be acute. This operation —linear extraction—is a relic of that surgical age when antisepsis was unknown. Performed for the purpose of relieving undue tension and evacuating the lenticular fragments, the very nature of the operation has been such as to diminish the first only temporarily and defeat the second indication frequently. The situation of the corneal incision has been such as to preclude the possibility of removing all the fragments of the swollen lens. The oblique course of the wound has rendered it patency impossible while favoring its closure. Furthermore, the incision made by the ordinary keratome was too short. That such objections are not chimerical can be seen by a study of the accompanying diagram:

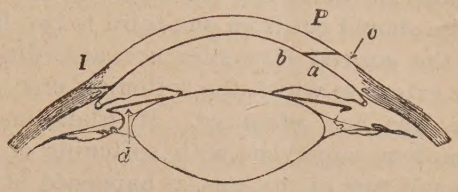

Fig. 1—Diagram showing site of corneal incision. The line, b. c., wound made by keratome in linear extraction. 1, site of wound in operations made by the writer.

In the cornea we find that flap wounds gape more than linear ones, but the tendency towards gaping depends more upon whether the wound traverses the cornea perpendicularly or obliquely. The former is more particularly the case in wounds made with the Graefe knife in which the knife passes through the cornea from within outwards, while the latter condition exists when the lance knife is used. These wounds do not gape, because the instrument passes obliquely through the cornea and the lips of the wound close like a valve. The closure is caused by intra-ocular pressure. This force presses as strongly upon the posterior lip (*a*) of the wound as upon the anterior (*b*). The wound must be made to gape before the softened lens matter can be evacuated. Gaping of the wound can be produced, not by the application of force opposite the site of corneal incision, but only by pressure applied just peripheral to the wound (at *c* in figure 1.) You can readily imagine that such a wound will not permit the removal of all the diseased mass; in fact, only the softest portion of the lens can be evacuated, and irrigation of the anterior chamber is not to be thought of. Such, then, are the objections to an operation which has the sanction of authority and the prestige of age. For reasons already mentioned I contend that this operation is unscientific.

Have I anything better to offer? The

propcsition which I have to advance is this: In case of traumatic cataract, with rapid increase of intra-ocular tension, an operation should be performed and that operation should be not linear extraction, as has been the rule heretofore, but an extraction made with the Graefe knife and with the incision located in the corneo-scleral junction. The knife should cut from one-third to two-fifths of the corneal circumference, according to the extent to which the softening process in the lens has advanced. If glaucomatous symptoms supervene with softening of only a small part of the lens, as happened in case I, which I will presently report, the corneal incision should be large; if the softening involves the whole of the lens the incision should be of less extent. The extent of the incision in the cornea, so far as healing is concerned, is of little importance, provided we make an aseptic operation. The chief merit of the operation which I am here to advocate lies in the avoidance of the valve which we saw produced by the linear method; in other words, my method in these cases permits the free evacuation of all the lenticular substance with the least amount of traumatism. An iridectomy is not made. All debris is removed at once. This cannot be accomplished by the linear method.

Removal of Foreign Bodies from the Cornea.

Medical News.

Mechanics and workmen have learned from oculists (who should have taught them better) the method of removing foreign bodies from the cornea by "picking them out" with some sharp or slightly blunted metal instrument. In every factory or workshop every day, and often many times a day, it occurs that pins, knives, etc., are thus blunderingly used, frequently with great injury to the cornea, with the resultant formation of corneal ulcers, keratitis, iritis, or, at least, leucomata. All text books of ophthalmology advise the use of the "corneal spud" for removing such particles, and every young physician supplies himself with the instrument. But it is the most outrageously ill-adapted for the purpose conceivable. It is impossible for any patient to hold the eye still enough to permit any hand thus to remove a partly imbedded grain of sand or emery, or what-not, without wounding the epithelium of the cornea. For this purpose a rigid tool is absurd, and a rigid metal instrument is the acme of absurdity. Every physician should teach workingmen how easy it is, and how free from any danger of injury, to remove the great majority of foreign bodies on the cornea with a simple wisp of cotton. Any particle not thus removable should not be sought after with penknives, awls, pins or spuds, but the patient should be sent to a physician. Twist a little wisp of absorbent cotton, having long fibers, upon itself until the fibrils are well caught but are not too densely packed upon each other. Fold the roll upon itself and grasp it half an inch from the rounded or curved extremity. The eyelids are held apart by the fingers of the left hand, and the patient instructed to look in such a direction as to bring the foreign body into view. By delicate, though firm pressure, the wisp of cotton is brushed, not to quickly, across the cornea, or it is given a slight twist or screw-like movement when deftly pressed against the cornea. Almost invariably the dust particle is removed at the first trial, being entangled or caught by the fibrils of the cotton. Cocaine, blepharostat, spud, time, labor and injury are all dispensed with and happily spared. The procedure may not be for the commercial advantage of the specialist, but it is worth more to the world than seven "original researches" and prize essays.

DR. H. W. MORGAN, of Clay Center, Kas., died in Denver, Colo., Jan. 19, 1895, of cerebro-spinal meningitis. The funeral was held in Clay Center January 22, and the body was taken to the family burying ground in Pella, Iowa. The full obituary notice will be given in the JOURNAL at an early date.

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Topeka, Kansas, Saturday, Jan. 26, 1895.

The Medical Bill.

The medical bill adopted by the physicians at the May meeting is now in the hands of both committees of the Legislature. The original committee of nine having been found too large and cumbersome, was called together and a subcommittee of three appointed to whom was referred the bill for such necessary changes as they deemed advisable. The bill was submitted to legal advice, and, as passed by the May meeting, found unconstitutional under our Kansas constitution, while the same was not true in Illinois where the law is now in active operation. We desire to say that only such changes were made in the bill as was deemed wise by the attorneys to make it conform to our constitution and save it should it get before the Supreme Court. The text of the law remains the same as agreed upon at the meeting of physicians.

We desire now to call the attention of all the physicians interested in medical legislation, and especially the legislative committee appointed last May, that the bill now begins to need their active attention and hearty support or we may meet with defeat, as all the quacks and quack medicine companies are now petitioning the Legislature to pass no law. This is a brief resume of the work done for medical legislation by the committee, and although they have been accused of bad faith by some, we can assure you that they have worked diligently to get a medical bill that will stand the test of courts. We sincerely hope all who are anxious for a medical law will give the committee their hearty support now by bracing up their representative to stand by his pre-election promise. Every physician should now consider himself a committee of one to come to Topeka and see his representative. We trust this will enlighten all regarding the actions of the legislative committee. For the benefit of those who desire to support the bill adopted at the May meeting, House bill 225, by Mr. Benifiel, and Senate bill 263, by Senator Smith, is the one agreed upon by the convention and submitted by its committee.

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Excision of Ossicles in Chronic Otorrhœa.

For some time there was considerable uncertainty among aurists as to the results from surgical procedures for the removal of sclerotic tissue and ankylosed elements of the ossicular chain, resulting from chronic otorrhœa. In Sajou's Annual for '94 Drs.

Turnbull and Bliss say: "It is now a generally acknowledged fact that, in cases of chronic otorrhœa which fail to yield to the older and less radical forms of treatment, it is the surgeon's duty to resort to excision. Abroad, especially in Germany, the surgeon feels justified in exposing the middle ear cavity by incising the attachment of the auricle, drawing it forward, separating the cartillaginous from the bony canal and, thus gaining a field for operation, remove all offending masses. Good results follow this method, and it offers the advantage of enabling the surgeon to drain the mastoid cells and antrum at the same time. In this country equally good results appear to have followed removal of diseased tissues through the external auditory canal, by means of delicate instruments and by the aid of a strong light, the electric head lamp being most useful."

Dr. Randall, of Philadelphia, regards the removal of the stapes as the most rational and accompanied with striking improvement in hearing, while there are no unfavorable results. It has been claimed that in a great many instances the great improvement in hearing has been only temporary. It seems, however, that in those cases where the sound *perceiving* functions are intact, and when other methods have failed, that excision gives sufficient promise of benefit to warrant the aurist in doing the operation.

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Removal of Tonsils.

We have advocated the removal of the tonsils for some time with the cold snare instead of the tonsillotome. The only difficulty we have encountered is in some cases where the tonsils were very tough we were not able by the strength of the hand to cut through them in every instance and had the wire to break in one case and could not free the imbedded wire from the tonsil. In the case of tough tonsil there was no difficulty in holding the tonsil out and cutting it off smoothly with a pair of long blunt pointed scissors. More difficulty was experienced with the broken wire one end being caught and held in the tissue and in attempting to cut the tonsil encountered the wire a number of times but finally succeeded in getting outside of the wire, leaving a ragged stump. The snare used was the ordinary nasal snare. It is seldom that difficulty is encountered and when the pressure or force required is very great I use the scissors to avoid breaking the wire aud hurting my hand. In the ordinary soft tonsil and in those of children the snare has many advantages. It is easy of application, does not produce the gagging and retching and fright that the tonsillotome does. It is neat and clean and can be left around the tonsil like a polypus in the nose and gradually strangulated without such a choking feeling as there is caused by a large instrument. It does not require any particular training to throw the wire loop over the tonsil and the hemorrhage is much less and the pain is no greater. The wire loop will catch a smaller tonsil than the ordinary tonsillotome and children will permit many trials to be made because of the small size of the wire, it not looking like a surgical instrument and the size causes but little if any choking sensation which always frightens them.

The Surgical Treatment of Chronic Empyema of the Antrum Maxillare.

Journal of Laryngology, October, 1894.

Spicer (London) advises the following in those cases of empyema of the antrum which resist the ordinary measures. General anesthetic; crucial incision over the canine fossa; with chisel and mallet a large opening into the anterior wall of the antrum; bone chipped away to the level of the floor of the antrum, and a groove established down the alveolus; interior explored with the finger; curetted. The next step is to make two large openings into the antrum from the nasal cavity, the trochar and canula being inserted into the inferior meatus well behind the nasal duct opening. (The advantage of pushing the trochar from the

nose into the antrum is that the particles of bone broken by the trochar can be removed. A dental drill might be used for this purpose, and these openings could be made, under cocaine, the following day.—J. D.) After irrigation of the antrum it is packed with creolin gauze (iodoform gauze is probably better. It may be added here that a good way of applying iodoform to the antral cavity, where our opening is the usual one through the root of a tooth, is to suspend the iodoform in albolene [℥j to ℥j] and inject with a dental syringe.) The gauze is allowed to remain forty-eight hours. No form of mechanical drain is used. Free irrigation thrice daily. Patient is instructed to force air through antrum into mouth.

Sublimate Solutions.

Dr. Charles Stedman Bull, in the New York Academy of Medicine, said in regard to "Subconjunctival Injections of Sublimate Solutions in Chronic Diseases of the Eyeball":

"Darrier and others claim that solutions injected under the conjunctiva rapidly penetrate the various parts of the eye. Darrier uses a Pravaz syringe, and makes the injection antiseptically under cocaine anæsthesia at a distance of six or eight millimeters from the corneal margin. He uses a one-to-one-thousand solution of bichloride of mercury, and injects one-twentieth of a milligramme. The number of injections varies from three or four to fifty or sixty, according to the chronicity of the disease. He claims to have had no serious complications except some severe pain and some œdema. He concludes that in all cases of infectious diseases, the result of mechanical irritation or of severe traumatism, these injections afford the most rapid method of limiting the local process, and act as an efficient aid to the more usual methods. It has been used by others in the treatment of syphilitic affections of the eye, and apparently with success.

"A review of the literature of the subject shows a great diversity of opinion among various observers as to the value of this new treatment for the relief of similar conditions. We have no proof so far that these solutions actually penetrate into the interior of the eye. The advocates of the treatment usually inject one-twentieth of a milligramme at a time, a part of which passes into the general circulation, while another part is lost in the conjunctival sac, so that an almost infinitesimal dose is left to exert its antiseptic action. In the treatment of sympathetic ophthalmia by this means, it is of course supposed that this disease is of a parasitic nature, or is due to micro-organisms, but this theory cannot be considered as at all proved.

"My own experience has not been very extensive, but during the past year I have employed these sub-conjunctival injections in 48 cases, as follows: Parenchymatous keratitis, 6; abscess of the cornea with hypopyon, 8; scleritis and episcleritis, 2; syphilitic iritis, 10; irido-choroiditis, 15; traumatic orbital cellulitis, 3; sympathetic ophthalmia, 2; and syphilitic neuroretinitis, 2. The solution used was a 1:1000 solution of the bichloride of mercury, and one-twentieth of a milligramme was injected each time. Of the six cases of parenchymatous keratitis three were of the vascular variety. The number of injections varied from three to ten, at intervals of one week. Severe reaction occurred in several of the cases after the first injection. In none of the cases was there any material benefit, yet none of these were made worse. The two cases of scleritis were marked instances of the disease occurring in syphilitics. The reaction in both was marked, and the pain severe. The cases certainly progressed to recovery more rapidly than under the usual methods of treatment. The ten cases of iritis were of the plastic variety and occurred in syphilitics. None was of the gummatous variety. The reaction was so severe in four cases that I was afraid to repeat the injections. In none of the cases was there any benefit observed. The pain in every case was severe. Of the fifteen cases of irido-choroiditis, eleven were syphilitics. The four non-syphilitic cases were acute and accompanied

by severe pain. One of the syphilitic cases appeared to be benefited, but no such improvement was observed in the other syphilitics. Three of the four non-syphilitics showed marked improvement. The pain was severe in all the cases. The three cases of traumatic orbital cellulitis bore the injections very well. In spite of the absence of reaction the cases pursued their usual course, and recovery without any evidence of benefit from this method of treatment. In the two cases of sympathetic ophthalmia the process was made decidedly worse by the injections, and the duration was prolonged. Both were cases of comparatively recent traumatism, and both were instances of advanced sympathetic inflammation. I should not be inclined to employ the method again in this class of cases. In the two cases of syphilitic neuro-retinitis, the reaction was quite moderate. Both cases recovered usual vision, but I cannot say that the treatment by injections shortened the disease at all, and I should not employ them again in such cases.

"To summarize:

"1. The pain is always severe.

"2. The reaction is apt to be severe, and is sometimes very serious.

"3. The only classes of cases in which the sublimate injections seemed to exert any positive effect in allaying the symptoms and shortening the duration were those of scleritis and acute irido-choroiditis of the non-syphilitic type.

"4. The treatment is still on trial and should not be promiscuously employed in all sorts of cases as a routine treatment."

Quinine Amaurosis.

Dr. John Herbert Claiborne, in New York Medical Journal.

Some time ago Dr. De Schweinitz gave quinine hypodermically to dogs, in quantities of from one to four grains to the pound, with the result of producing blindness in from three to fourteen hours. The effect of the drug was obtained more readily by administering the bimuriate of quinine with the carbamide of urea. The symptoms of vomiting, staggering, and convulsions attended the blindness, with two exceptions; in these there were no symptoms attending the blindness.

The ophthalmoscopic picture was similar in every case to that in the human subject. The pupils in all cases were immovably dilated. In one case there was thrombosis of the central vein. Examination with the microscope showed that toxic doses of quinine could produce thrombosis of the central vein, and that neither neuritis nor atrophy in the true sense of the word was present in the animal longest blind (nearly a month), but that there appeared to be a species of œdema between the optic nerve and chiasm.

Dr. Schweinitz then undertook additional experiments to settle four points:

1. Whether blindness could be produced in dogs by other salts than those used.

2. Whether the prolongation of quinine amaurosis would produce true atrophy.

3. Whether the production of thrombosis or embolism is to be expected in severe cases.

4. Whether the apparent degeneration of the cells of the cuneus found in the first experiments was the result of the hardening process, or due to true lesion from the drug.

His subsequent experiments showed that blindness could be produced effectively by other salts of quinine, dissolved with the aid of tartaric acid or dilute hydrochloric acid.

In regard to the second proposition he proved by microscopic examination that prolonged quinine blindness caused a true atrophy of the optic nerve, chiasm and tracts.

In regard to the third proposition it was shown that thrombosis of the central vessels may be expected in severe cases.

He found, however, that the degeneration of the cells of the cuneus was due to the hardening process and not to the drug.

From the study of this subject the following conclusions may be drawn:

1. Quinine in toxic doses may produce blindness.

2. The toxic dose is distinctly indeterminate.

3. The duration of the amaurosis varies largely.

4. The field of vision remains contracted.

5. Central vision usually returns to the normal.

6. There is color blindness at first; the color perception is ultimately within the central field.

7. The ophthalmoscopic picture is that of white atrophy.

8. Experiments on dogs show that there is atrophy of the entire optic tract.

9. The same experiments show that the cells of the cuneus are probably not affected.

10. Treatment is of no avail.

Nasal Treatment.

American Journal of the Medical Sciences, December, 1894.

Gradle (*Journal of the American Medical Association*, vol. xx, No. 22), in considering the benefit to ear patients from nasal treatment, concludes as follows:

1. Acute suppurative inflammation of the middle ear, if not treated locally, has a tendency to become chronic, the tendency increasing with the age of the patient.

2. Chronic suppuration of the middle ear rarely heals without treatment. Neither acute nor chronic purulent otitis is influenced by nasal treatment, but the liability to relapses after cure is decidedly lessened by the removal of naso-pharyngeal anomalies.

3. Acute catarrh of the middle ear will generally terminate in complete recovery under aural treatment, and sometimes without it, provided there are no persistent nasal or pharyngeal lesions. But when these are present, the disease is more likely to become chronic in spite of aural treatment, and in many instances can either not be cured, or, if improved, will speedily relapse unless the normal state of the nose and throat is restored.

4. Proliferation or adhesive disease of the middle ear is the consequence of retro-nasal catarrh, and its course is determined by the course of the disorder causing it. Aural treatment alone is practically useless in this form of trouble, while nasal treatment, if successful as far as the catarrh is concerned, will also arrest the ear disease.

The restitution of hearing, however, depends upon the length of time the disease has lasted, and is often aided by the ear treatment after the cure of the retro-nasal catarrh.

The Care of the Ear During the Course of the Exanthemata.

The Medical Bulletin.

Dowine (*Journal of Laryngology, Rhinology and Otology*, August, 1894) says that two-fifths of all middle-ear cases examined by him originated during the course of measles and scarlet fever; but this does not indicate the number of cases in which the ear is affected during these diseases, but rather points to the proportion of chronic ear affections which follow them. Many acute cases prove fatal; while others, on account of their acute character, have active treatment applied early, by which structural changes are prevented. For relief of nasal discharges the patient should be directed, from the very beginning of illness, to use the handkerchief freely; and if the child is too young to do this, Politzer inflation should be resorted to. Where the case does not come under observation till a late stage, and the pain in the ear is acute, and relief is not obtained by inflation, the membrane should be examined and incised without delay, especially if there be a sudden rise in temperature without any other explanation. This operation is of incalculable benefit to the patient, for it not only relieves the immediate pain, but saves the deeper structures of the ear and prevents the misery of a chronic otorrhœa, with its numerous attendant risks.

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Sarcoma of the Palate Successfully Treated by Toxins of Erysipelas.

The Therapeutic Gazette.

Johnson (*American Medico-Surgical Bulletin*, November 15, 1894) reports the following case:

"A clerk, 16 years old, presented himself with a sarcomatous infiltration of the soft palate; the swelling extended over the pillars of the fauces down the wall of the pharynx over the base of the tongue, and involved the larynx as far as the true vocal chords. Several of the cervical glands were enlarged. Microscopic examination showed the growth to be spindle-celled sarcoma. Injections of the toxins of erysipelas and the bacillus prodigiosus (in doses of 13 minims daily of the former and 5 minims daily of the latter) were administered. The dose was eventually increased to 40 minims. These injections were given sometimes in the arm and sometimes in the leg, and caused swelling, redness, and pain, and an elevation of temperature of 99° to 103° F. Sometimes there were chills, followed by profuse sweating.

"The treatment was continued with occasional intermissions eight months. There were in all not over a dozen severe chills. After one of these the temperature rose to 103° F., the patient became cyanotic, and was so ill as to be obliged to remain in bed for two weeks. Keratitis developed after five months' treatment. Injections were stopped for three weeks during the most severe period of this attack.

"The result of treatment was a steady but slow improvement in his condition. There was an increase in weight, a diminution of glandular swelling. Eleven months after the patient first came under observation he had gained twenty-one pounds, and showed in the throat simply a slight central prominence of sarcomatous tissue; in the center of the palate were bands extending to the pillars of the fauces, due to the cicatricial contraction of the new tissue, some of the sarcomatous tissue having disappeared by absorption and some by microbiosis.

"Coley, in commenting upon this case, says that he saw it before treatment was begun, and had no hope of giving it more than temporary relief. He further remarked that in five cases of cancer in which he looked for cure after erysipelas injections, none have shown any signs of return of the trouble; one has gone over a period of three years, two over two years, and others over one year.

"Since the publication of his paper, giving details of twenty-five cases of inoperable sarcoma and eight of carcinoma, he has treated ten cases of sarcoma, three having been extraordinarily successful. One was an enormous sarcoma of the ilium, filling the right side of the abdomen. On commencing the toxin treatment, March, 1894, the tumor began to break down and slough out. After five weeks' treatment the injections were stopped. This prolonged process of sloughing was depressing to the patient, but, by stimulation and careful treatment, he began to improve, and was exhibited recently without any tumor, having gained in three months thirty pounds.

"In another case, that of a girl of 16, with a sarcoma of four months' duration, situated in the left scapular region and extending to the median line in the back, and filling the axilla to the median line in front, the arm could be raised in three weeks. No breaking down occurred. The injections were given in the scapular regions only. She is now apparently cured. Similar results have been observed in other cases.

"Dr. Johnson used the erysipelas and prodigiosus toxins, filtered and grown separately, and gave them in small doses in combination.

"Coley states that he has recently had better results from the two germs grown together and unfiltered. A temperature of 58° C. is sufficient to kill the germs without destroying the chemical properties. Sufficient thymol is added to make a saturated solution. The value of the preparation lies in the virulence of the culture from which it is obtained. In all of Coley's cases the culture came from a fatal case of erysipelas."

Eastern Kansas Medical Society.

The Eastern Kansas Medical Society met in A. O. U. W. Hall January 8, 1895, President R. E. McVey, M.D., in the chair.

Minutes of last meeting read and approved.

Members present: Drs. J. L. King, Junction City; J. H. Ketchersid, Hope; L. Reynolds, Horton; J. A. Lane, and M. S. Thomas, Leavenworth; J. B. Connell, Kansas City, Mo.; W. E. McVey, Violet Church, Agnes McKee Wallace, Ida Barnes, Maggie L. McCrea, J. L. Gilbert, L. H. Munn, W. S. Lindsay, H. C. Miner, J. E. Minney, Geo. L. Beers, S. E. Sheldon, Frances Stoors, R. S. Magee, Topeka.

The application of Dr. D. D. Wilson, of Nortonville, for membership was received.

Dr. Minney presented an interesting paper on "Intra-ocular Sarcoma with Report of Case," with microscopical illustrations by J. L. Gilbert, M.D.

The next paper of the evening was by Dr. J. B. Connell, of Kansas City, Mo., on "Modes and Causes of Death—Medico-Legal Autopsies." (This paper will be published in the JOURNAL.)

In opening the discussion Dr. Lane said: We owe our thanks to the author for this paper. The doctor sacrifices his dignity when he steps aside from a medical standpoint and attempts to take sides in a case of death by injury when called to testify. A doctor must not take sides, but state the facts plainly as he found them. It is not our fault if the case be not plain. He is oftentimes placed in an uncomfortable position when cross-questioned by an attorney.

Dr. Gilbert thought it a timely paper and worthy of investigation.

Dr. R. E. McVey asked whether the coroner had a right to hold his examination and investigations secretly?

Dr. King recited an instance in which he had held an inquest in a case of injury at the request of friends and received the censure of the coronor. Asked whether he deserved the censure or not.

Drs. Munn, Reynold's and Teft wished to be recorded as indorsing the paper.

In closing Dr. Connell said that no physician has the right to make a post mortem in case of death by injury—only the coroner—he is a judicial officer. The body should not be moved until the coroner comes and views it. In answer to Dr. McVey's question, the coroner has the right to hold his investigations secretly, the opposing party has the privilege of being present if he so desires. As to the color of the clot being an infallible test, as brought out by some one in discussion, we cannot say it is absolutely infallible, but pretty generally so. Occasionally we have the white ante mortem clot in pneumonia.

Dr. Gilbert read a paper on Hyaline Degeneration. It was discussed by Drs. Munn and Connell. (The paper will be published in the JOURNAL.)

Dr. Reynolds read a paper on some surgical cases in his practice with a report of a post mortem. Cases—One laryngeal obstruction; 3 cases of strangulated hernia; 3 cases of pyosalpinx; one ruptured tubal pregnancy, and one of appendicitis, without operation, and death—the other eight cases recovered. This paper will be published.)

In discussion, Dr. Sheldon said this is a lot of interesting cases with which we are likely to come in contact every day in our practice. It is a mistake to allow taxis for any length of time in cases of hernia. To a gut, suspicious of necrosis, warm saline applications should be made. All operations in these cases should be done early. I only use sterilized water in these operations, for I am convinced that chemical antiseptics oftentimes do more harm than good.

Dr. Ketchersid: I am convinced that I have seen death result from prolonged taxis. Operate early. If in doubt as to condition of gut before returning it to the abdomen, cover it over with gauze and wait and time will tell.

Dr. Connell would like to ask the author as to the benefits of ice applications in reduction of hernia?

Dr. Reynolds, in closing, said we need not

fear as to the results of surgical relief in strangulated hernia; it is successful. I have found ice good therapeutics in the spontaneous reduction of hernia, particularly in children. A case in my own family, after repeated applications of taxis, ice applied brought the desired result. The program was carried out to the letter; all of the papers were on hand.

The committee on necrology made the following report on the death of Drs. O'Brien and Alexander:

WHEREAS, On August 28, 1894, occurred the death of Dr. M. O'Brien, our brother, and fellow of the Eastern Kansas Medical Society; be it

Resolved, That we remember with sorrow this loss of one out of our ranks, one whose force of character and capabilities had carried him on a successful career in the line of his profession, in service both public and private; one from whose vigorous manhood we had reason to expect years of usefulness and pleasant association; and further

Resolved, That the upright character of this man and the fortitude with which he calmly met and discussed the reality of his end shall stimulate us to manliness in all things;

Resolved, That a copy of these resolutions be transmitted to the family.

W. J. LINDSAY, Ch'n.
J. C. MCCLINTOCK,
A. H. CORDIER,
A. L. FULTON,
A. P. TENNEY,
Committee.

WHEREAS, On October 8, 1894, one of our worthy fellows, Dr. Reid Alexander, was separated from us by that transition called death; therefore, be it

Resolved by the Eastern Kansas Medical Society, That we feel keenly the loss of our brother, whose counsel and participation in the programs of our meetings did much in our interest as physicians; further

Resolved, That as we meet here again in the hall where we have frequently met Dr. Alexander, that we miss the genial fellowship and hearty grasp of the hand of one by whose untimely death the science of medicine has lost a faithful student and an earnest advocate; one whose manly qualities endeared him alike to his associate physicians and his patients as a valued counselor and a loyal friend.

Resolved, That a copy of these resolutions be presented to the family.

W. L. LINDSAY, Ch'n.
J. C. MCCLINTOCK,
A. H. CORDIER,
A. L. FULTON,
A. P. TENNEY,
Committee.

The place of next meeting will be in Topeka the second Tuesday of April.

Adjourned.

R. S. MAGEE, M.D., Secretary,

Eye-Strain a Cause of Nocturnal Enuresis.

Medical News.

Dr. Geo. M. Gould reports a number of cases of children who were afflicted with nocturnal enuresis, that were cured by correction of the ocular defect by glasses In most of the children the involuntary urination was accompanied by many other nervous symptoms, such as night terrors, headaches, chorea, etc., nearly all of which were also relieved or cured by glasses that corrected the visual anomaly. Some of the patients had undergone operations and treatment that had extended over years without relief of the trouble.

WE are always pleased to hear pleasant things said of our patrons. In talking with one of Topeka's pharmacists a few days ago, he said, in speaking of some of Lehn & Fink's preparations, that they manufactured a very fine line of goods and were in every way a first-class house.

REMEMBER that we will furnish you the JOURNAL for one year and Helbing's Modern Materia Medica for $2.50.

Resolutions of Respect.

CLAY CENTER, KAS., January 24.

At a called meeting of the physicians of Clay county, held in the office of Stewart & Scott, on January 23, 1895, at which were present Drs. A. Pearson, M. C. Porter, D. C. Tyler, R. J. Morton, D. J. Moore, J. W. Kretzmeier, W. A. Schenberger, J. P. Stewart, J. R. Scott, and J. E. Minney of Topeka, the following resolutions were adopted:

WHEREAS, The Almighty Ruler of the Universe saw fit to remove from among us Dr. H. W. Morgan; and

WHEREAS, Dr. Morgan was an efficient and conscientious physician and worthy member of our profession;

Resolved, That we, his associates, extend to Mrs. Morgan and family and to the brothers of the deceased our sympathy and condolence in their sad affliction;

Resolvcd,, That a copy of these resolutions be sent to the wife and brothers of the deceased, to the county papers and KANSAS MEDICAL JOURNAL.

M. C. PORTER, President.
J. R. SCOTT, Secretory.

The following resolutions were passed by the students of the Kansas Medical College:

WHEREAS, On the night of January 19, 1895, the Angel of death visited the home of MRS. H. W. Morgan and ended forever the efficient labors of her husband, Dr. H. W. Morgan; and

WHEREAS, Mrs. Morgan is a student of the Kansas Medical College, known and respected by all the students for her careful and earnest work and kindly disposition; therefore

Resolved, That we, the students of the of the Kansas Medical College, unite in sending to her our sincere condolence and earnest sympathy in this, her great loss and deep sorrow.

L. C. DUNCAN,
JESSIE K. CLARKE,
ROBT. MCCANDLASS,
Committee.

Inflammation of the Middle Ear of Infants.

American Journal of Medical Sciences.

Dr. A. Hartman (*Deutsche med. Wochenschrift*) gives the results of investigations of this subject in the Institute for Infectious Diseases, Berlin:

1. Post mortem examinations and examinations of the ears of living children establish the fact that 75 per cent. suffer from inflammation of the middle ear.

2. Inflammation of the middle ear can nearly always be determined by an otoscopic examination.

3. The symptoms of the otitis media consist of restlessness, elevation of temperature and loss of weight. Sometimes these symptoms are not present.

4. Very often the symptoms of otitis media are connected with broncho-pneumonic processes. Probably both processes are due to the same process, viz., aspiration.

5. Death can result in cases of otitis media, slow stone atrophy, or from an extension of the micro-organisms into the cranial cavity (meningitis), or into the blood (septicemia).

6. The inflammation of the middle ears of infants must receive treatment suitable for the varying conditions.

What Is the Status of the Ophthalmic Colleges.

Medical Fortnightly.

In Chicago are two institutions, the so-called ophthalmic colleges, which manufacture oculists and opticians *ad nauseam*. In either case a course lasting six weeks suffices to lead to a diploma. This diploma is not a degree in medicine, in midwifery, in dentistry, or in veterinary science. It is *sui generis* and has no standing in law. If its possessor has been a registered physician who has complied with the medical practice act of the State in which he lives, he has a legal standing; but his diploma from the

ophthalmic college does not of itself entitle him to practice. Dozens of graduates from these institutions are engaged in medical practice either as "opticians" or as "oculists." Under the circumstances we wish to know: What is the status of the ophthalmic colleges. Will the Illinois State Board of Medical Examiners please answer?

By referring to the most reliable works on bacteriology, particularly Sternberg, which has a compilation of the value and power of all known antiseptic drugs as discovered by experimentalists and investigators of the highest repute, we find that the effective ingredients of pasteurine are capable of arresting the life of germs or destroying them in the following proportions: Cinnamon oil, 1 to 500 or 3,000. The essence kills the bacillus of typhoid fever in twelve minutes. Citric acid, 1 to 200, in which proportion it destroys germs of cholera in a half hour. Eucalyptus, 1 to 80. Gaultheria, 1 to 70. The tests by which these figures have been arrived at were made by different authors with a variety of pathogenic germs —tuberculosis, typhoid fever, cholera, various pus and septic germs, etc. The combination—pasteurine—acts equally well on the ærobic and anærobic germs, on mucous membranes, mouth, alimentary canal, etc., it is unequalled.

GOTHENBURG, NEB., Jan. 15, 1895.

The Mercer Chemical Co., Omaha. Neb.

Gentlemen: Mr. W., married, age 39. Since having an attack of paralysis of the left side two years ago has suffered complete impotence—I say complete advisedly, as he had not experienced in all this time the first sign of even a partial erection. I confess my great surprise and satisfaction after 24 days treatment with Pill Vita, blue, (Mercer) to have the patient report himself entirely restored to full power. I consider the results in this case to have been most remarkable, and the verdict—guilty of using the Mercer Chemical Company's Pill Vita (blue)—has created happiness in a barren household and reunited a now happy couple.

Yours truly,

DR. W. P. SMITH,

Assistant Surgeon U. P. Rly.

Transplantation of the Human Cornea.

Medical Record.

At a recent meeting of the Vienna Society of Physicians, Professor Fuchs exhibited a case of transplantation of the human cornea. It is well known that Professor Hippel ha. sueceeded in transplanting pieces of ths cornea in four cases; but the pieces of core nea that he transplanted were small, whil- Professor Fuchs used flaps of from four te five millimetres in diameter. Large pieceo of cornea, when transplanted, do not bes come opaque so soon as small ones. The- pieces for transplantation used by Professor Fuchs in this case were taken from a human eye. Four weeks had elapsed at the time of exhibition since the operation had been performed, and the piece implanted was perfectly transparent, while in previous cases the opacity had commenced after the tenth day.

Announcement.

E. B. Treat, publisher, New York, has in press for early publication the 1895 "International Medical Annual," being the thirteenth yearly issue of this eminently useful work. Since the first issue of this one volume reference work, each year has witnessed marked improvements; and the prospectus of the forthcoming volume gives promise that it will surpass any of its predecessors. It will be the conjoint authorship of thirty-eight distinguished contributors and specialists, from America, England and the continent. It will contain the progress of medical science in all parts of the world, together with a large number of original articles and reviews by authors on subjects with which their scientific reputation is identified. In short, the design of the book is to bring the practitioner into direct communication with those who are advancing the science of medicine, so he may be furnished with all that is worthy of preservation as reliable aids in his daily work. Illustrations in black and colors will be freely used in elucidating the text. A most useful investment for the medical practitioner. The price remains the same as heretofore, $2.75.